Chapter 700c: Health Statutes

Available from the Connecticut General Assembly, at: **http://www.cga.ct.gov/2011/pub/chap700c.htm**

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
1	Sec. 38a-476. Preexisting condition coverage See Sec. 38a-476 for similar provisions re individual policies.	(a)(1) For the purposes of this section, "health insurance plan" means any hospital and medical expense incurred policy, hospital or medical service plan contract and health care center subscriber contract and does not include (A) short-term health insurance issued on a nonrenewable basis with a duration of 6 months or less, accident only, credit, dental, vision, Medicare supplement, long-term care or disability insurance, hospital indemnity coverage, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payments insurance, or insurance under which beneficiaries are payable without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, or (B) policies of specified disease or limited benefit health insurance, provided that the carrier offering such policies files on or before March first of each year a certification with the Insurance Commissioner that contains the following: (i) A statement from the carrier certifying that such policies are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance; (ii) a summary description of each such policy including the average annual premium rates, or range of premium rates in cases where premiums vary by age, gender or other factors, charged for such policies in the state; and (iii) in the case of a policy that is described in this subparagraph and that is offered for the first time in this state on or after 10/1/1993, the carrier files with the commissioner the information and statement required in this subparagraph at least 30 days prior to the date such policy is issued or delivered in this state. (2) "Insurance arrangement" means any "multiple employer welfare arrangement", as defined in Section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, except for any such arrangement which is fully insured within the meaning of Section 514(b)(6) of said act, as amended. (3) "Preexisting conditions provision" means a policy provision which limits or excludes benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, for which any medical advice, diagnosis, care or treatment was recommended or received before such effective date. Routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment for purposes of this section unless evidence of breast cancer is found during or as a result of such follow-up. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. Pregnancy shall not be considered a preexisting condition. (4) "Qualifying coverage" means (A) any group health insurance plan, insurance arrangement or self-insured plan, (B) Medicare or Medicaid, or (C) an individual health insurance plan that provides benefits which are actuarially equivalent to or exceeding the benefits provided under the small employer health care plan, as defined in subdivision (12) of section 38a-564, whether issued in this state or any other state. (5) "Applicable waiting period" means the period of time imposed by the group policyholder or contractholder before an individual is eligible for participating in the group policy or contract. (b) (1) No group health insurance plan or insurance arrangement shall impose a preexisting conditions provision that excludes coverage for a period beyond 12 months following the insured's effective date of coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the six months immediately preceding the effective date of coverage. (2) No individual health insurance plan or insurance arrangement shall impose a preexisting conditions provision that excludes coverage beyond 12 months following the insured's effective date of coverage. Any preexisting conditions provision shall only relate to conditions, whether physical or mental, for which medical advice, diagnosis or care or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage. (c) All health insurance plans and insurance arrangements shall provide coverage, under the terms and conditions of their policies or contracts, for the preexisting conditions of any newly insured individual who was previously covered for such preexisting condition under the terms of the individual's preceding qualifying coverage, provided the preceding coverage was continuous to a date less than one hundred twenty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, except in the case of a newly insured group member whose previous coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
		dependent applies for such succeeding coverage within thirty days of the member's or dependent's initial eligibility. (d) With respect to a newly insured individual who was previously covered under qualifying coverage, but who was not covered under such qualifying coverage for a preexisting condition, as defined under the new health insurance plan or arrangement, such plan or arrangement shall credit the time such individual was previously covered by qualifying coverage to the exclusion period of the preexisting condition provision, provided the preceding coverage was continuous to a date less than 120 prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan, except in the case of a newly insured group member whose preceding coverage was terminated due to an involuntary loss of employment, the preceding coverage must have been continuous to a date not more than one hundred fifty days prior to the effective date of the new coverage, exclusive of any applicable waiting period, provided such newly insured group member or dependent applies for such succeeding coverage within thirty days of the member's or dependent's initial eligibility. (e) Each insurance company, fraternal benefit society, hospital service corporation, medical service corporation or health care center which issues in this state group health insurance subject to Section 2701 of the Public Health Service Act, as set forth in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, shall comply with the provisions of said section with respect to such group health insurance, except that the longer period of days specified in subsections (c) and (d) of this section shall apply to the extent excepted from preemption in Section 2723(B)(2)(iii) of said Public Health Service Act. (f) The provisions of this section shall apply to every health insurance plan or insurance arrangement issued, renewed or continued in this state on or after October 1, 1993. For purposes of this section, the date a plan or arrangement is continued shall be the anniversary date of the issuance of the plan or arrangement. The provisions of subsection (e) of this section shall apply on and after the dates specified in Sections 2747 and 2792 of the Public Health Service Act as set forth in HIPAA. (g) Notwithstanding the provisions of subsection (a) of this section, a short-term health insurance policy issued on a nonrenewable basis for six months or less which imposes a preexisting conditions provision shall be subject to the following conditions: (1) No such preexisting conditions provision shall exclude coverage beyond twelve months following the insured's effective date of coverage; (2) such preexisting conditions provision may only relate to conditions, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received during the twenty-four months immediately preceding the effective date of coverage; and (3) any policy, application or sales brochure issued for such short-term health insurance policy that imposes such preexisting conditions provision shall disclose in a conspicuous manner in not less than fourteen-point bold face type the following statement: "THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE." In the event an insurer or health care center issues two consecutive short-term health insurance policies on a nonrenewable basis for six months or less which imposes a preexisting conditions provision to the same individual, the insurer or health care center shall reduce the preexisting conditions exclusion period in the second policy by the period of time such individual was covered under the first policy. If the same insurer or health care center issues a third or subsequent such short-term health insurance policy to the same individual, such insurer or health care center shall reduce the preexisting conditions exclusion period in the third or subsequent policy by the cumulative time covered under the prior policies. Nothing in this section shall be construed to require such short-term health insurance policy to be issued on a guaranteed issue or guaranteed renewable basis. (h) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to enforce the provisions of HIPAA and this section concerning preexisting conditions and portability.
2	38a-477b. Post claims underwriting prohibited unless approval granted. Application for approval of rescission, cancellation or limitation.	(a) Unless approval is granted pursuant to subsection (b) of this section, no insurer or health care center may rescind, cancel or limit any policy of insurance, contract, evidence of coverage or certificate that provides coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 on the basis of written information submitted on, with or omitted from an insurance application by the insured if the insurer or health care center failed to complete medical underwriting and resolve all reasonable medical questions related to the written information submitted on, with or omitted from the insurance application before issuing the policy, contract, evidence of coverage or certificate. No insurer or health care center may rescind, cancel or limit any such policy, contract, evidence of coverage or certificate more than two years after the effective date of the policy, contract, evidence of coverage or certificate. (b) An insurer or health care center shall apply for approval of such rescission, cancellation or limitation by submitting such written

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	Decision. Appeals. Regulations See Sec. 38a-477b for similar provisions re individual policies.	information to the Insurance Commissioner on an application in such form as the commissioner prescribes. Such insurer or health care center shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than seven business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to review such application and respond and submit relevant information to the commissioner with respect to such application. Not later than fifteen business days after the submission of information by the insured or the insured's representative, the commissioner shall issue a written decision on such application. The commissioner may approve such rescission, cancellation or limitation if the commissioner finds that (1) the written information submitted on or with the insurance application was false at the time such application was made and the insured or such insured's representative knew or should have known of the falsity therein, and such submission materially affects the risk or the hazard assumed by the insurer or health care center, or (2) the information omitted from the insurance application was knowingly omitted by the insured or such insured's representative, or the insured or such insured's representative should have known of such omission, and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center. (c) Notwithstanding the provisions of chapter 54, any insurer or insured aggrieved by any decision by the commissioner under subsection (b) of this section may, within thirty days after notice of the commissioner's decision is mailed to such insurer and insured, take an appeal therefrom to the superior court for the judicial district of Hartford, which shall be accompanied by a citation to the commissioner to appear before said court. Such citation shall be signed by the same authority, and such appeal shall be returnable at the same time and served and returned in the same manner, as is required in case of a summons in a civil action. Said court may grant such relief as may be equitable. (d) The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of this section.
3	Sec. 38a-513c. Group health insurance policy to contain definition of "medically necessary" or "medical necessity". See Sec. 38a-482a for similar provisions re individual policies. See Sec. 38a-482a for similar provisions re individual policies.	(a) No insurer, health care center, hospital and medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this state on or after January 1, 2008, shall deliver or issue for delivery in this state any such policy unless such policy contains a definition of "medically necessary" or "medical necessity" as follows: "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment. (b) The provisions of subsection (a) of this section shall not apply to any insurer, health care center, hospital and medical service corporation or other entity that has entered into any national settlement agreement until the expiration of any such agreement
4	Sec. 38a-513d. Insurers prohibited from issuing policy with limited coverage to employer as replacement for a comprehensive health insurance	a) No insurer, health care center, hospital service corporation, medical service corp. or other entity delivering, issuing for delivery, renewing, continuing or amending any group health insurance policy in this state on or after 1/1/08, shall deliver or issue for delivery in this state any policy providing limited coverage to any employer as a replacement for a comprehensive health insurance plan for its employees. (b) Each group health insurance policy, subscriber contract or certificate of coverage delivered or issued for delivery in this state on or after 1/1/08, that provides limited coverage, & any marketing material, application for coverage & enrollment material relative to such policy, contract or certificate, shall include the following statement printed in capital letters in not less than 12-point bold face type and located in a conspicuous manner on such document:"THIS LIMITED HEALTH BENEFITS PLAN DOES NOT PROVIDE COMPREHENSIVE MEDICAL COVERAGE.

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	plan. Disclosure required in policy providing limited coverage. Limited coverage defined. See Sec. 38a-482b for similar provisions re individual policies.	IT IS A BASIC OR LIMITED BENEFITS POLICY AND IS NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS PLAN IS NOT DESIGNED TO COVER THE COSTS OF SERIOUS OR CHRONIC ILLNESS. IT CONTAINS SPECIFIC DOLLAR LIMITS THAT WILL BE PAID FOR MEDICAL SERVICES WHICH MAY NOT BE EXCEEDED. IF THE COST OF SERVICES EXCEEDS THOSE LIMITS, THE BENEFICIARY AND NOT THE INSURER IS RESPONSIBLE FOR PAYMENT OF THE EXCESS AMOUNTS. THE SPECIFIC DOLLAR LIMITS ARE AS FOLLOWS: (INSURER TO SPECIFY SUCH AMOUNTS)." (c) For the purposes of this section, "limited coverage" means an insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) &(12) of section 38a-469 that contains an annual maximum benefit of less than $100,000 or fixed dollar benefits of less than $20,000 on any core services. For the purpose of this section, "core services" means medical, surgical & hospital services, including inpatient and outpatient physician, laboratory & imaging services
5	Sec. 38a-513b. Coverage and notice re experimental treatments. Appeals. See Sec. 38a-483c for similar provisions re individual policies	(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2000, shall define the extent to which it provides coverage for experimental treatments. (b) No such health insurance policy may deny a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration (FDA). Any person who has been diagnosed with a condition that creates a life expectancy in that person of less than 2 years & who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental may request an expedited appeal as provided in section 38a-226c and may appeal a denial thereof to the Insurance Commissioner in accordance with the procedures established in section 38a-478n. (d) For the purposes of conducting an appeal pursuant to section 38a-478n on the grounds that an otherwise covered procedure, treatment or drug is experimental, the basis of such an appeal shall be the medical efficacy of such procedure, treatment or drug. The entity conducting the review may consider whether the procedure, treatment or drug (1) has been approved by the National Institute of Health or the American Medical Association, (2) is listed in the United States Pharmacopoeia Drug Information Guide for Health Care Professionals (USP-DI), the American Medical Association Drug Evaluations (AMA-DE), or the American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI), or (3) is currently in a phase III clinical trial of the federal FDA.
6	Sec. 38a-514. (Formerly Sec. 38-174d). Mandatory coverage for the diagnosis & treatment of mental or nervous conditions. Exceptions. Benefits payable re type of provider or facility. State's claim against proceeds. See Sec. 38a-488a for similar provisions re individual policies	(a) Except as provided in subsection (j) of this section, each group health insurance policy, providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state on or after 1/1/2000, shall provide benefits for the diagnosis & treatment of mental or nervous conditions. For the purposes of this section, "mental or nervous conditions" means mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "*Mental or nervous conditions" does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the* most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". (b) No such group policy shall establish any terms, conditions or benefits that place a greater financial burden on an insured for access to diagnosis or treatment of mental or nervous conditions than for diagnosis or treatment of medical, surgical or other physical health conditions. (c) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for the same services when such services are lawfully rendered by a psychologist licensed under the provisions of chapter 383 or by such a licensed psychologist in a licensed hospital or clinic. (d) In the case of benefits payable for the services of a licensed physician or psychologist, such benefits shall be payable for the same services when such services are rendered by: (1) A clinical social worker who is licensed under the provisions of chapter 383b and who has passed the clinical examination of the American Association of State Social Work Boards and has completed at least 2,000 hours of post-master's social work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the Internal Revenue Code (IRC) of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Dept. of Public Health under section 19a-490; (2) A social worker who was certified as an independent social worker under the provisions of chapter 383b prior to 10/1/90; (3) A licensed marital and family therapist who has

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
		completed at least 2,000 hours of post-master's marriage and family therapy work experience in a nonprofit agency qualifying as a tax-exempt organization under Section 501(c) of the IRC of 1986 or any subsequent corresponding internal revenue code of the United States, as from time to time amended, in a municipal, state or federal agency or in an institution licensed by the Dept. of Public Health under section 19a-490; (4) A marital & family therapist who was certified under the provisions of chapter 383a prior to October 1, 1992; (5) A licensed alcohol and drug counselor, as defined in section 20-74s, or a certified alcohol and drug counselor, as defined in section 20-74s; or (6) A licensed professional counselor. (e) For purposes of this section, the term "covered expenses" means the usual, customary & reasonable charges for treatment deemed necessary under generally accepted medical standards, except that in the case of a managed care plan, as defined in section 38a-478, "covered expenses" means the payments agreed upon in the contract between a managed care organization, as defined in section 38a-478, & a provider, as defined in section 38a-478. (f) (1) In the case of benefits payable for the services of a licensed physician, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of a psychiatrist, physician, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section. (2) In the case of benefits payable for the services of a licensed psychologist under subsection (d) of this section, such benefits shall be payable for (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of such licensed psychologist, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement under subdivisions (1) to (4), inclusive, of subsection (d) of this section; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement under subdivision (5) of subsection (d) of this section; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement under subdivision (6) of subsection (d) of this section. (g) In the case of benefits payable for the service of a licensed physician practicing as a psychiatrist or a licensed psychologist, under subsection (d) of this section, such benefits shall be payable for outpatient services rendered (1) in a nonprofit community mental health center, as defined by the Dept. of Mental Health and Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited hospital or in a residential treatment facility; (2) under the supervision of a licensed physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor, or a licensed professional counselor who is eligible for reimbursement under subdivisions (1) to (6), inclusive, of subsection (d) of this section; and (3) within the scope of the license issued to the center or clinic by the Dept. of Public Health or to the residential treatment facility by the Dept. of Children and Families. (h) Except in the case of emergency services or in the case of services for which an individual has been referred by a physician affiliated with a health care center, nothing in this section shall be construed to require a health care center to provide benefits under this section through facilities that are not affiliated with the health care center. (i) In the case of any person admitted to a state institution or facility administered by the Dept. of Mental Health and Addiction Services, Dept. of Public Health, Dept. of Children & Families or the Department of Developmental Services, the state shall have a lien upon the proceeds of any coverage available to such person or a legally liable relative of such person under the terms of this section, to the extent of the per capita cost of such person's care. Except in the case of emergency services the provisions of this subsection shall not apply to coverage provided under a managed care plan, as defined in section 38a-478. (j) A group health insurance policy may exclude the benefits required by this section if such benefits are included in a separate policy issued to the same group by an insurance company, health care center, hospital service corporation, medical service corporation or fraternal benefit society. Such separate policy, which shall include the benefits required by this section and the benefits required by section 38a-533, shall not be required to include any other benefits mandated by this title. (k) In the case of benefits based upon confinement in a residential treatment facility, such benefits shall be payable in situations in which the insured has a serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
		of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting. (l) The services rendered for which benefits are to be paid for confinement in a residential treatment facility must be based on an individual treatment plan. For purposes of this section, the term "individual treatment plan" means a treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.
7	Sec. 38a-514b. Coverage for autism spectrum disorders. See Sec. 38a-488b for provisions re individual policies	(a) As used in this section: (1) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior. (2) "Autism services provider" means any person, entity or group that provides treatment for autism spectrum disorders pursuant to this section. (3) "Autism spectrum disorders" means the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified. (4) "Behavioral therapy" means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are: (A) Provided to children less than fifteen years of age, and (B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed physician, or (iii) a licensed psychologist. For the purposes of this subdivision, behavioral therapy is "supervised by" such behavior analyst, licensed physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the autism services provider by such behavior analyst, licensed physician or licensed psychologist for each ten hours of behavioral therapy provided by the supervised provider. (5) "Diagnosis" means the medically necessary assessment, evaluation or testing performed by a licensed physician, licensed psychologist or licensed clinical social worker to determine if an individual has an autism spectrum disorder. (b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 that is delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for the diagnosis and treatment of autism spectrum disorders. For the purposes of this section and section 38a-513c, an autism spectrum disorder shall be considered an illness.(c) Such policy shall provide coverage for the following treatments, provided such treatments are (1) medically necessary, & (2) identified and ordered by a licensed physician, licensed psychologist or licensed clinical social worker for an insured who is diagnosed with an autism spectrum disorder, in accordance with a treatment plan developed by a licensed physician, licensed psychologist or licensed clinical social worker pursuant to a comprehensive evaluation or reevaluation of the insured: (A) Behavioral therapy; (B) Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such policy, prescribed by a licensed physician, licensed physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of autism spectrum disorders; (C) Direct psychiatric or consultative services provided by a licensed psychiatrist; (D) Direct psychological or consultative services provided by a licensed psychologist; (E) Physical therapy provided by a licensed physical therapist; (F) Speech and language pathology services provided by a licensed speech and language pathologist; and (G) Occupational therapy provided by a licensed occupational therapist. (d) Such policy may limit the coverage for behavioral therapy to a yearly benefit of $50,000 for a child who is less than 9 years of age, $35,000 for a child who is at least nine years of age and less than thirteen years of age and $25,000 for a child who is at least 13 years of age & less than 15 years of age. (e) Such policy shall not impose (1) any limits on the number of visits an insured may make to an autism services provider pursuant to a treatment plan on any basis other than a lack of medical necessity, or (2) a coinsurance, copayment, deductible or other out-of-pocket expense for such coverage that places a greater financial burden on an insured for access to the diagnosis & treatment of an autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical or physical health condition under such policy. (f) (1) Except for treatments and services received by an insured in an inpatient setting, an insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society may review a treatment plan developed as set forth in subsection (c) of this section for such insured, in accordance with its utilization review requirements, not more than once every 6 months unless such insured's licensed

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
		physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or changes such insured's treatment plan. (2) For the purposes of this section, the results of a diagnosis shall be valid for a period of not less than twelve months, unless such insured's licensed physician, licensed psychologist or licensed clinical social worker determines a shorter period is appropriate or changes the results of such insured's diagnosis. (g) Coverage required under this section may be subject to the other general exclusions and limitations of the group health insurance policy, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and case management provisions, except that any utilization review shall be performed in accordance with subsection (f) of this section. (h) (1) Nothing in this section shall be construed to limit or affect (A) any other covered benefits available to an insured under (i) such group health insurance policy, (ii) section 38a-514, or (iii) section 38a-516a, (B) any obligation to provide services to an individual under an individualized education program pursuant to section 10-76d, or (C) any obligation imposed on a public school by the Individual With Disabilities Education Act, 20 USC 1400 et seq., as amended from time to time. (2) Nothing in this section shall be construed to require such group health insurance policy to provide reimbursement for special education and related services provided to an insured pursuant to section 10-76d, unless otherwise required by state or federal law.
8	Sec. 38a-515. Continuation of coverage of mentally retarded or physically handicapped dependent children. See Sec. 38a-489 for similar provisions re individual policies.	(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) and (12) of section 38a-469 delivered or issued for delivery in this state more than one hundred twenty days after July 1, 1971, which provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child if at such date the child is and continues thereafter to be both (1) incapable of self-sustaining employment by reason of mental or physical handicap, as certified by the child's physician on a form provided by the insurer, hospital or medical service corporation, or health care center and (2) chiefly dependent upon such employee or member for support and maintenance. (b) Proof of the incapacity and dependency shall be furnished to the insurer, hospital or medical service plan corporation or health care center by the employee or member within thirty-one days of the child's attainment of the limiting age. The insurer, corporation or center may at any time require proof of the child's continuing incapacity and dependency. After a period of two years has elapsed following the child's attainment of the limiting age the insurer, corporation or center may require periodic proof of the child's continuing incapacity and dependency but in no case more frequently than once every year.
10	Sec. 38a-516a. Coverage for birth-to-3 program. See Sec. 38a-490a for similar provisions re individual policies.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide (1) coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's 3rd birthday, and (2) a maximum benefit of $6,400 per child per year and an aggregate benefit of $19,200 per child over the total 3-year period. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.
11	Sec. 38a-516b. Coverage for hearing aids for children 12 and under. See Sec. 38a-490b for similar provisions re individual policies.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state on or after 10/1/2001, shall provide coverage for hearing aids for children 12 years of age or younger. Such hearing aids shall be considered durable medical equipment under the policy and the policy may limit the hearing aid benefit to $1,000 within a 24-month period.

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
12	Sec. 38a-516c. Coverage for craniofacial disorders. See Sec. 38a-490c for similar provisions re individual policies.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after 10/1/2003, shall provide coverage for medically necessary orthodontic processes and appliances for the treatment of craniofacial disorders for individuals 18 years of age or younger if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association, except that no coverage shall be required for cosmetic surgery.
	Sec. 38a-516d. Coverage for neuropsychological testing for children diagnosed with cancer See Sec. 38a-492l for similar provisions re individual policies.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after 10/1/2006, shall provide coverage without prior authorization for each child diagnosed with cancer on or after 1/1/2000, for neuropsychological testing ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment.
14	Sec. 38a-517a. Coverage for in-patient, outpatient or 1-day dental services in certain instances. See Sec. 38a-491a for similar provisions re individual policies.	a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for general anesthesia, nursing & related hospital services provided in conjunction with in-patient, outpatient or one-day dental services if the following conditions are met: (1) The anesthesia, nursing and related hospital services are deemed medically necessary by the treating dentist or oral surgeon and the patient's primary care physician in accordance with the health insurance policy's requirements for prior authorization of services; and (2) The patient is either (A) determined by a licensed dentist, in conjunction with a licensed physician who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital, or (B) a person who has a developmental disability, as determined by a licensed physician who specializes in primary care, that places the person at serious risk. (b) The expense of such anesthesia, nursing and related hospital services shall be deemed a medical expense under such health insurance policy and shall not be subject to any limits on dental benefits under such policy.
15	Sec. 38a-518. Coverage for accidental ingestion or consumption of controlled drugs. See Sec. 38a-492 for similar provisions re individual policies.	No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6) & (11) of section 38a-469 shall be delivered, issued for delivery or renewed in this state, or amended to substantially alter or change benefits or coverage, on or after 7/1/1975, unless persons covered under such policy will be eligible for benefits for expenses of emergency medical care arising from accidental ingestion or consumption of a controlled drug, as defined by subdivision (8) of section 21a-240, which are at least equal to the following minimum requirements: (1) In the case of benefits based upon confinement as an inpatient in a hospital, whether or not operated by the state, the period of confinement for which benefits shall be payable shall be at least 30 days in any calendar year. (2) For covered expenses incurred by the insured while other than an inpatient in a hospital, benefits shall be available for such expenses during any calendar year up to a maximum of $500 hundred dollars. For purposes of this section, the term "covered expenses" means the reasonable charges for treatment deemed necessary under generally accepted medical standards.

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
16	Sec. 38a-518a. Mandatory coverage for hypodermic needles and syringes See Sec. 38a-492a for similar provisions re individual policies.	Every group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) & (12) of section 38a-469, delivered, issued for delivery or renewed in this state on or after 7/1/1992, shall provide coverage for hypodermic needles or syringes prescribed by a prescribing practitioner, as defined in subdivision (22) of section 20-571, for the purpose of administering medications for medical conditions, provided such medications are covered under the policy. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy.
17	Sec. 38a-518c. Coverage for low protein modified food products, amino acid modified preparations and specialized formulas. See Sec. 38a-492c for similar provisions re individual policies.	For purposes of this section: (1) "Inherited metabolic disease" includes (A) a disease for which newborn screening is required under section 19a-55; & (B) cystic fibrosis. (2) "Low protein modified food product" means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a physician (3) "Amino acid modified preparation" means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a physician.(4) "Specialized formula" means a nutritional formula for children up to age 12 that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal FDA & is intended for use solely under medical supervision in the dietary management of specific diseases.(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) & (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after 10/1/1997, shall provide coverage for amino acid modified preparations & low protein modified food products for the treatment of inherited metabolic diseases if the amino acid modified preparations or low protein modified food products are prescribed for the therapeutic treatment of inherited metabolic diseases and are administered under the direction of a physician.(c) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) & (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after 10/1/1997, shall provide coverage for specialized formulas when such specialized formulas are medically necessary for the treatment of a disease or condition & are administered under the direction of a physician.(d) Such policy shall provide coverage for such preparations, food products and formulas on the same basis as outpatient prescription drugs.
18	Sec. 38a-518d. Mandatory coverage for diabetes testing and treatment See Sec. 38a-492d for similar provisions re individual policies.	(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after 10/1/1997, shall provide coverage for laboratory & diagnostic tests for all types of diabetes. (b) Notwithstanding the provisions of section 38a-518a, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after 10/1/1997, shall provide medically necessary coverage for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes & non-insulin-using diabetes. Such coverage shall include medically necessary equipment, in accordance w/ the insured person's treatment plan, drugs & supplies prescribed by a prescribing practitioner, as defined in section 20-571.
19	Sec. 38a-518e. Mandatory coverage for diabetes outpatient self-management training. See Sec. 38a-492e	(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state on or after 1/1/2000, shall provide coverage for outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if the training is prescribed by a licensed health care professional who has appropriate state licensing authority to prescribe such training. As used in this section, "outpatient self-management training" includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care within the scope of the professional's practice. (b) Benefits shall cover: (1) Initial training

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	for similar provisions re individual policies.	visits provided to an individual after the individual is initially diagnosed with diabetes that is medically necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, totaling a maximum of 10 hours; (2) training and education that is medically necessary as a result of a subsequent diagnosis by a physician of a significant change in the individual's symptoms or condition which requires modification of the individual's program of self-management of diabetes, totaling a maximum of 4 hours; &(3) training & education that is medically necessary because of the development of new techniques and treatment for diabetes totaling a maximum of 4 hours. (c) Benefits provided pursuant to this section shall be subject to the same terms and conditions applicable to all other benefits under such policies.
20	Sec. 38a-518g. Mandatory coverage for prostate cancer screening. See Sec. 38a-492g for similar provisions re individual policies	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state on or after 1/1/2000, shall provide coverage for laboratory and diagnostic tests, including, but not limited to, prostate specific antigen (PSA) tests, to screen for prostate cancer for men who are symptomatic, whose biological father or brother has been diagnosed with prostate cancer, and for all men 50 years of age or older.
21	Sec. 38a-518h. Mandatory coverage for certain Lyme disease treatments See Sec. 38a-492h for similar provisions re individual policieS.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state on or after 1/1/2000, shall provide coverage for Lyme disease treatment including not less than thirty days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both, and shall provide further treatment if recommended by a board certified rheumatologist, infectious disease specialist or neurologist licensed in accordance with chapter 370 or who is licensed in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of this state.
22	Sec. 38a-518i. Mandatory coverage for pain management. See Sec. 38a-492i re individual health insurance coverage for pain management.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) & (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state on or after 1/1/2001, shall provide access to a pain management specialist and coverage for pain treatment ordered by such specialist which may include all means medically necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures. As used in this section, "pain" means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves, & "pain management specialist" means a physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.
23	Sec. 38a-518j. Mandatory coverage for ostomy-related supplies See Sec. 38a-492j for similar provisions re individual policies.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for ostomy surgery shall include coverage, up to $1,000 annually, for medically necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. As used in this section, "ostomy" includes colostomy, ileostomy & urostomy. Payments under this section shall not be applied to any policy maximums for durable medical equipment. Nothing in this section shall be deemed to decrease policy benefits in excess of the limits in this section.

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
24	Sec. 38a-518k. Mandatory coverage for colorectal cancer screening. See Sec. 38a-492k for similar provisions re individual policies	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) &(12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after 10/1/ 2001, shall provide coverage for colorectal cancer screening, including, but not limited to, (1) an annual fecal occult blood test, & (2) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American College of Gastroenterology, after consultation with the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations. Benefits under this section shall be subject to the same terms and conditions applicable to all other benefits under such policies.
26	Sec. 38a-518m. Mandatory coverage for certain wound-care supplies. See Sec. 38a-492n for similar provisions re individual policies.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 that is delivered, issued for delivery, renewed, amended or continued in this state on or after 1/1/2010, shall provide coverage for wound-care supplies that are medically necessary for the treatment of epidermolysis bullosa and are administered under the direction of a physician.
27	Sec. 38a-520. Mandatory coverage for home health care. Deductibles. Exception from deductible limits for medical savings accounts. Archer MSAs and health savings accounts. See Sec. 38a-493 for similar provisions re individual policies	(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) &(12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after 10/1/1975, shall provide coverage providing reimbursement for home health care (HHC) to residents in this state.(b) For the purposes of this section, "hospital" means an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients (1) diagnostic, surgical and therapeutic services for medical diagnosis, treatment & care of injured, disabled or sick persons, or (2) medical rehabilitation services for the rehabilitation of injured, disabled or sick persons, provided "hospital" shall not include a residential care home, nursing home, rest home or alcohol or drug treatment facility, as defined in section 19a-490. For the purposes of this section and section 38a-494, "HHC" means the continued care and treatment of a covered person who is under the care of a physician but only if (A) continued hospitalization would otherwise have been required if HHC was not provided, except in the case of a covered person diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live, and (B) the plan covering the HHC is established and approved in writing by such physician within 7 days following termination of a hospital confinement as a resident inpatient for the same or a related condition for which the covered person was hospitalized, except that in the case of a covered person diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live, such plan may be so established and approved at any time irrespective of whether such covered person was so confined or, if such covered person was so confined, irrespective of such 7 day period, and (C) such HHC is commenced within 7 days following discharge, except in the case of a covered person diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live.(c) Home health care shall be provided by a home health agency. The term "home health agency" means an agency or organization which meets each of the following requirements: (1) It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services, (2) its policies are established by a professional group associated with such agency or organization, including at least one physician and at least one registered nurse, to govern the services provided, (3) it provides for full-time supervision of such services by a physician or by a registered nurse, (4) it maintains a complete medical record on each patient, and (5) it has an administrator (d) HHC shall consist of, but shall not be limited to, the following: (1) except in the case of a covered person diagnosed as terminally ill w/ a prognosis of 6 months or less to live, and by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; (2) part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; (3) physical, occupational or speech therapy; (4) medical

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
		supplies, drugs and medicines prescribed by a physician, an advanced practice registered nurse or a physician assistant and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; (5) medical social services, as hereinafter defined, provided to or for the benefit of a covered person diagnosed by a physician as terminally ill with a prognosis of 6 months or less to live. Medical social services are defined to mean services rendered, under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to (A) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment; (B) appropriate action and utilization of community resources to assist in resolving such problems; (C) participation in the development of the overall plan of treatment for such covered person. (e) The policy may contain a limitation on the number of HHC visits for which benefits are payable, but the number of such visits shall not be less than eighty in any calendar year or in any continuous period of twelve months for each person covered under a policy, except in the case of a covered person diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the yearly benefit for medical social services shall not exceed $200 . Each visit by a representative of a home health agency shall be considered as 1 HHC visit; 4 hours of home health aide service shall be considered as 1 HHC visit. (f) HHC benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy and may be subject to a coinsurance provision which provides for coverage of not less than 75% of the reasonable charges for such services. Such policy may also contain reasonable limitations and exclusions applicable to HHC coverage. A "high deductible health plan", as defined in Section 220(c)(2) or Section 223(c)(2) of the IRC of 1986, or any subsequent corresponding IRC of the United States, as from time to time amended, used to establish a "medical savings account" or "Archer MSA" pursuant to Section 220 of said IRC or a "health savings account" pursuant to Section 223 of said IRC shall not be subject to the deductible limits set forth in this subsection. (g) No policy, except any major medical expense policy as described in subsection (j), shall be required to provide HHC coverage to persons eligible for Medicare. (h) No insurer, hospital service corporation or health care center shall be required to provide benefits beyond the maximum amount limits contained in its policy. (i) If a person is eligible for HHC coverage under more than one policy, the HHC benefits shall only be provided by that policy which would have provided the greatest benefits for hospitalization if the person had remained or had been hospitalized. (j) Each major medical expense policy delivered, issued for delivery or renewed in this state on or after 10/1/1989, shall provide coverage in accordance with the provisions of this section for HHC to residents in this state whose benefits are no longer provided under Medicare or any applicable individual or group health insurance policy.
28	Sec. 38a-554. (Formerly Sec. 38-374). Additional requirements and eligibility under group comprehensive health care plans. Coverage for stepchildren. Continuation of benefits under group plans. Ins. Commissioner's authority to coordinate benefits. See Sec. 38a-497 for similar provisions re individual policies	A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38a-553 & shall also conform in substance to the requirements of this section.(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the purposes of this section; and (3) unmarried children who are under 26 years of age. Each plan shall cover a stepchild on the same basis as a biological child. (b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for other group insurance, except as provided in subdivisions (3) & (4) of this subsection:(1) Notwithstanding any provision of this section, upon layoff, reduction of hours, leave of absence or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for a period of thirty months after the date of such layoff, reduction of hours, leave of absence or termination of employment, except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act (2) Upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the COBRA of 1985, P.L. 99-272, as amended from time to time;(3) Regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence;(4) Regardless of an individual's eligibility for other group insurance, upon termination of the group plan, coverage for covered individuals who were totally disabled on

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
		the date of termination shall be continued without premium payment during the continuance of such disability for a period of 12 calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within 1 year of the termination of the plan;(5) The coverage of any covered individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in which the child: Marries; ceases to be a resident of the state; becomes covered under a group health plan through the dependent's own employment; or attains the age of 26. The residency requirement shall not apply to dependent children under 19 years of age or full-time students attending an accredited institution of higher education. If on the date specified for termination of coverage on a child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within 31 days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the COBRA of 1985, P.L. 99-272, as amended from time to time; (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the COBRA of 1985, P.L. 99-272, as amended from time to time; and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act; (6) As to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in 29 USC 1162, as amended from time to time. Any continuation of coverage required by this section except subdivision (4) or (6) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 & 38a-551 to 38a-559, inclusive, to pay such premium if not paid timely by the employee. (c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance plans. No individual or group health insurance plan shall coordinate benefits or otherwise reduce benefit payments because a person is covered by or receives benefits from a group specified disease policy delivered, issued for delivery, renewed, amended or continued in this state. (d) The plan shall make available to CT residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan. (e) (1) The provisions of subdivision (1) of subsection (b) of this section shall apply to any individual for whom such continuation of coverage is in effect or who elects continuation of coverage pursuant to this section, on or after 5/5/ 2010. (2) Each insurer & health care center that has issued a group health insurance policy subject to sections 38a-546 & 38a-554 shall, in conjunction with their group policyholders, including employers with fewer than 20 employees, provide notice of the continuation of coverage period specified in subdivision (1) of subsection (b) of this section to such individuals set forth in subdivision (1) of this subsection not later than 60 days after 5/5/2010.
29	Sec. 38a-525. Mandatory coverage for medically necessary ambulance	(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) & (12) of section 38a-469 delivered, issued for delivery, renewed or amended in this state on or after 10/1/2002, shall provide coverage for medically necessary ambulance services for persons covered by the policy. The hospital policy shall be primary if a person is covered under more than one policy. The policy shall, as a minimum requirement, cover such services whenever any person covered by the contract is transported when medically necessary by ambulance to a hospital. Such benefits shall be subject to any policy provision

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	services. Direct payment to ambulance provider. See Sec. 38a-497 for similar provisions re individual policies	which applies to other services covered by such policies. Notwithstanding any other provision of this section, such policies shall not be required to provide benefits in excess of the maximum allowable rate established by the Dept. of Public Health in accordance with section 19a-177. (b) (1) Each such group health insurance policy shall provide that any payment by such company, corporation or center for emergency ambulance services under coverage required by this section shall be paid directly to the ambulance provider rendering such service if such provider has complied with the provisions of this subsection and has not received payment for such service from any other source. (2) Any ambulance provider submitting a bill for direct payment pursuant to this section shall stamp the following statement on the face of each bill: "NOTICE: This bill subject to mandatory assignment pursuant to CT general statutes". (3) This subsection shall not apply to any transaction between an ambulance provider & an insurance company, hospital or medical service corporation, health care center or other entity if the parties have entered into a contract providing for direct payment.
30	Sec. 38a-525b. Mandatory coverage for mobile field hospital. See Sec. 38a-498b for similar provisions re individual policies.	Each group health insurance policy providing coverage of the type specified in subdivisions (1) to (13), inclusive, of section 38a-469 delivered, issued for delivery, renewed, amended or continued in the state on or after 7/1/ 2005, shall provide benefits for isolation care and emergency services provided by the state's mobile field hospital. Such benefits shall be subject to any policy provisions that apply to other services covered by such policy. The rates paid by group health insurance policies pursuant to this section shall be equal to the rates paid under the Medicaid program, as determined by the Dept. of Social Services.
31	Sec. 38a-525c. Denial of coverage prohibited for health care services rendered to persons with an elevated blood alcohol content. See Sec. 38a-498c for similar provisions re individual policies.	No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after 10/1/2006, shall deny coverage for health care services rendered to treat any injury sustained by any person when such injury is alleged to have occurred or occurs under circumstances in which (1) such person has an elevated blood alcohol content, or (2) such person has sustained such injury while under the influence of intoxicating liquor or any drug or both. For the purposes of this section, "elevated blood alcohol content" means a ratio of alcohol in the blood of such person that is eight-hundredths of one per cent or more of alcohol, by weight.
32	Sec. 38a-530. Mandatory coverage for mammography and breast ultrasound.Breast density information included in mammography report. See Sec. 38a-503	Breast density information included in mammography report. (a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state on or after 10/1/2001, shall provide benefits for mammographic examinations to any woman covered under the policy which are at least equal to the following minimum requirements: (1) A baseline mammogram for any woman who is 35 to 39 years of age, inclusive; and (2) a mammogram every year for any woman who is 40 years of age or older. Such policy shall provide additional benefits for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse. (b) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy. (c) On and after 10/1/12009, each mammography report provided to a patient shall include information about

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	for similar provisions re individual policies	breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report.
33	Sec. 38a-530c. Mandatory coverage for maternity care. Notice required. See Sec. 38a-503c for similar provisions re individual policies**.**	(a) As used in this section, "carrier" means each insurer, health care center, hospital and medical service corporation, or other entity delivering, issuing for delivery, renewing or amending any group health insurance policy in this state on or after 10/1/1996, providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) &(12) of section 38a-469. (b) Each group insurance carrier that offers maternity benefits shall provide coverage of a minimum of 48 hours of inpatient care for a mother and her newborn infant following a vaginal delivery and a minimum of 96 hours of inpatient care for a mother and her newborn infant following a caesarean delivery. The time periods shall commence at the time of delivery. (c) Any decision to shorten the length of inpatient stay to less than that provided under subsection (b) of this section shall be made by the attending health care providers after conferring with the mother. (d) If a mother and newborn are discharged pursuant to subsection (c) of this section, prior to the inpatient length of stay provided under subsection (b) of this section, coverage shall be provided for a follow-up visit within 48 hours of discharge & an additional follow-up visit within seven days of discharge. Such follow-up services shall include, but not be limited to, physical assessment of the newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system and the performance of any medically necessary & appropriate clinical tests. Such services shall be consistent with protocols and guidelines developed by attending providers or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and newborn pediatric care. (e) Each group insurance carrier shall provide notice to policyholders regarding the coverage required under this section. The notice shall be in writing & shall be transmitted at the earliest of either the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder or 1/1/1997.
34	Sec. 38a-530d. Mandatory coverage for mastectomy care. Termination of provider contract prohibited. See Sec. 38a-503d for similar provisions re individual policies.	(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) & (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after 7/1/1997, shall provide coverage for at least 48 hours of inpatient care following a mastectomy or lymph node dissection, and shall provide coverage for a longer period of inpatient care if such care is recommended by the patient's treating physician after conferring with the patient. No such insurance policy may require mastectomy surgery or lymph node dissection to be performed on an outpatient basis. Outpatient surgery or shorter inpatient care is allowable under this section if the patient's treating physician recommends such outpatient surgery or shorter inpatient care after conferring with the patient. (b) No group health insurance carrier may terminate the services of, require additional documentation from, require additional utilization review, reduce payments or otherwise penalize or provide financial disincentives to any attending health care provider on the basis that the provider orders care consistent with the provisions of this section.
35	Sec. 38a-530e. Mandatory coverage for prescription contraceptives. See Sec. 38a-503e for similar provisions re individual policies.	(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed or continued in this state on or after 10/1/1999, that provides coverage for outpatient prescription drugs approved by the federal FDA shall not exclude coverage for prescription contraceptive methods approved by the federal FDA. (b) (1) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer a group health insurance policy that excludes coverage for prescription contraceptive methods which are contrary to the religious employer's bona fide religious tenets. (2) Notwithstanding any other provision of this section, upon the written request of an individual who states in writing that prescription contraceptive methods are contrary to such individual's religious or moral beliefs, any insurance company, hospital or medical service corporation, or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
		prescription contraceptive methods. (c) Any health insurance policy issued pursuant to subsection (b) of this section shall provide written notice to each insured or prospective insured that prescription contraceptive methods are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than 10-point type, in the policy, application and sales brochure for such policy. (d) Nothing in this section shall be construed as authorizing a group health insurance policy to exclude coverage for prescription drugs ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes. (e) Notwithstanding any other provision of this section, any insurance company, hospital or medical service corporation, or health care center which is owned, operated or substantially controlled by a religious organization which has religious or moral tenets which conflict with the requirements of this section may provide for the coverage of prescription contraceptive methods as required under this section through another such entity offering a limited benefit plan. The cost, terms and availability of such coverage shall not differ from the cost, terms and availability of other prescription coverage offered to the insured. (f) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization" as defined in 26 USC 3121 or a church-affiliated organization.
36	Sec. 38a-534. Mandatory coverage for chiropractic services. See Sec. 38a-507 for similar provisions re individual policies.	Every group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6) and (11) of section 38a-469, delivered, issued for delivery or renewed in this state on or after 10/1/1989, shall provide coverage for services rendered by a chiropractor licensed under chapter 372 to the same extent coverage is provided for services rendered by a physician, if such chiropractic services (1) treat a condition covered under such policy and (2) are within those services a chiropractor is licensed to perform.
37	Sec. 38a-535 Mandatory coverage for preventive pediatric care & blood lead screening and risk assessment.	(a) For purposes of this section, "preventive pediatric care" means the periodic review of a child's physical & emotional health from birth through 6 years of age by or under the supervision of a physician. Such review shall include a medical history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards. (b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (11) & (12) of section 38a-469 delivered, issued for delivery or renewed on or after 10/1/1989, or continued as defined in section 38a-531, on or after 10/1/1990 shall provide benefits for preventive pediatric care for any child covered by the policy or contract at approximately the following age intervals: Every 2 months from birth to 6 months of age, every 3 months from 9 to 18 months of age & annually from 2 through 6 years of age. Any such policy may provide that services rendered during a periodic review shall be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit. On and after 1/1/2009, each such policy shall also provide coverage for blood lead screening and risk assessments ordered by a primary care provider pursuant to section 19a-111g. Such benefits shall be subject to any policy provisions which apply to other services covered by such policy.
38	Sec. 38a-536. Mandatory coverage for infertility diagnosis and treatment. Limitations. See Sec. 38a-509 for similar provisions re individual	(a) Subject to the limitations set forth in subsection (b) of this section and except as provided in subsection (c) of this section, each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) &(12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state on or after 10/1/2005, shall provide coverage for the med necessary expenses of the diagnosis & treatment of infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intra-fallopian transfer & low tubal ovum transfer. For purposes of this section, "infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period. (b) Such policy may: (1) Limit such coverage to an individual until the date of such individual's 40th birthday; (2) Limit such coverage for ovulation induction to a lifetime maximum benefit of 4 cycles; (3) Limit such coverage for intrauterine insemination to a lifetime maximum benefit of 3 cycles; (4) Limit lifetime benefits to a maximum of 2 cycles, with not more than 2 embryo implantations per

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	policies.	cycle, for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as 1 cycle; (5) Limit coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under such policy. Nothing in this subdivision shall be construed to deny the coverage required by this section to any individual who foregoes a particular infertility treatment or procedure if the individual's physician determines that such treatment or procedure is likely to be unsuccessful; (6) Require that covered infertility treatment or procedures be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility; (7) Limit coverage to individuals who have maintained coverage under such policy for at least 12 months; & (8) Require disclosure by the individual seeking such coverage to such individual's existing health insurance carrier of any previous infertility treatment or procedures for which such individual received coverage under a different health insurance policy. Such disclosure shall be made on a form and in the manner prescribed by the Insurance Commissioner. (c) (1) Any insurance company, hospital or medical service corporation, or health care center may issue to a religious employer a group health insurance policy that excludes coverage for methods of diagnosis and treatment of infertility that are contrary to the religious employer's bona fide religious tenets. (2) Upon the written request of an individual who states in writing that methods of diagnosis and treatment of infertility are contrary to such individual's religious or moral beliefs, any insurance company, hospital or medical service corporation, or health care center may issue to or on behalf of the individual a policy or rider thereto that excludes coverage for such methods. (d) Any health insurance policy issued pursuant to subsection (c) of this section shall provide written notice to each insured or prospective insured that methods of diagnosis and treatment of infertility are excluded from coverage pursuant to said subsection. Such notice shall appear, in not less than ten-point type, in the policy, application and sales brochure for such policy. (e) As used in this section, "religious employer" means an employer that is a "qualified church-controlled organization", as defined in 26 USC 3121 or a church-affiliated organization.
39	Sec. 38a-541. (Formerly Sec. 38-262h). Group health policy to allow spouse coverage as both employee and dependent, when. Effect of collective bargaining agreements.	Every health insurance policy issued under a group insurance plan and by an insurance company, hospital or medical service corporation, health care center or fraternal benefit society, delivered, issued for delivery or renewed in this state shall allow the spouse of any employee participating in such or any other group insurance plan offered by the same employer to be covered as an employee in addition to being covered as a dependent of such participating employee, except that benefits provided under such combined coverage of the employee as an employee and as a dependent shall not be in excess of 100% of the charge for the covered expense or service. The provisions of this section shall apply only where a husband and wife are employed by the same employer and by reason of their employment are both participating in a group insurance plan. Nothing in this section shall alter or impair existing group health insurance policies or contracts which have been established pursuant to an agreement which resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal & completion of such collective bargaining agreement.
40	Sec. 38a-542. Mandatory coverage for treatment of tumors and leukemia. Mandatory coverage for reconstructive surgery, prosthesis, chemotherapy &	(a) Each insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state group health insurance policies providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 shall provide coverage under such policies for treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any nondental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy, and costs of removal of any breast implant which was implanted on or before 7/1/1994, without regard to the purpose of such implantation, which removal is determined to be med necessary. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. (b) Except as provided in subsection (c) of this section, the coverage required by

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	wigs. Orally administered anticancer medications. See Sec. 38a-504 for similar provisions re individual policies.	subsection (a) of this section shall provide at least a yearly benefit of $1,000 for the costs of removal of any breast implant, $500 for the surgical removal of tumors, $500 for reconstructive surgery, $500 for outpatient chemotherapy, $300 for a wig and $300 for a nondental prosthesis, except that for purposes of the surgical removal of breasts due to tumors the yearly benefit for such prosthesis shall be at least $300 for each breast removed. (c) The coverage required by subsection (a) of this section shall provide benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. For the purposes of this subsection, reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy. (d) (1) Each policy of the type specified in subsection (a) of this section that provides coverage for intravenously administered and orally administered anticancer medications used to kill or slow the growth of cancerous cells, that are prescribed by a prescribing practitioner, as defined in section 20-571, shall provide coverage for orally administered anticancer medications on a basis that is no less favorable than intravenously administered anticancer medications. (2) No insurance company, hospital service corporation, medical service corporation, health care center or fraternal benefit society that delivers, issues for delivery, renews, amends or continues in this state a policy of the type specified in subsection (a) of this section, shall reclassify such anticancer medications or increase the coinsurance, copayment, deductible or other out-of-pocket expense imposed under such policy for such medications, to achieve compliance with this subsection.
41	Sec. 38a-542a. Cancer clinical trials: Coverage for routine patient care costs. See Sec. 38a-504a for similar provisions re individual policies.	Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) & (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after 1/1/2002, shall provide coverage for the routine patient care costs, as defined in section 38a-542d, associated with cancer clinical trials, in accordance with sections 38a-542b to 38a-542g, inclusive. As used in this section and sections 38a-542b to 38a-542g, inclusive, "cancer clinical trial" means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by 1 of the entities identified in section 38a-542b and is conducted at multiple institutions.
42	Sec. 38a-542b. Cancer clinical trials: When eligible for coverage. See Sec. 38a-504b for similar provisions re individual policies.	In order to be eligible for coverage of routine patient care costs, as defined in section 38a-542d, a cancer clinical trial shall be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: (1) One of the National Institutes of Health; or (2) a National Cancer Institute affiliated cooperative group; or (3) the federal FDA as part of an investigational new drug or device exemption; or (4) the federal Dept. of Defense or Veterans Affairs. Nothing in sections 38a-542a to 38a-542g, inclusive, shall be construed to require coverage for any single institution cancer clinical trial conducted solely under the approval of the institutional review board of an institution, or any trial that is no longer approved by an entity identified in subdivision (1), (2), (3) or (4) of this section.
43	Sec. 38a-542c. Cancer clinical trials: Evidence and information re eligibility for. No coverage required for otherwise reimbursable costs.	In order to be eligible for coverage of routine patient care costs, as defined in section 38a-542d, the insurer, health care center or plan administrator may require that the person or entity seeking coverage for the cancer clinical trial provide: (1) Evidence satisfactory to the insurer, health care center or plan administrator that the insured person receiving coverage meets all of the patient selection criteria for the cancer clinical trial, including credible evidence in the form of clinical or pre-clinical data showing that the cancer clinical trial is likely to have a benefit for the insured person that is commensurate with the risks of participation in the cancer clinical trial to treat the person's condition; and (2) evidence that the appropriate informed consent has been received from the insured person; and (3) copies of any medical records, protocols, test results or other clinical information used by the physician or institution seeking to enroll the insured person in the cancer clinical trial; and (4) a summary of the anticipated routine patient care costs in excess of the costs for standard treatment;

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	See Sec. 38a-504c for similar provisions re individual policies.	and (5) information from the physician or institution seeking to enroll the insured person in the clinical trial regarding those items, including any routine patient care costs, that are eligible for reimbursement by an entity other than the insurer or health care center, including the entity sponsoring the clinical trial; and (6) any additional information that may be reasonably required for the review of a request for coverage of the cancer clinical trial. The health plan or insurer shall request any additional information about a cancer clinical trial within five business days of receiving a request for coverage from an insured person or a physician seeking to enroll an insured person in a cancer clinical trial. Nothing in sections 38a-542a to 38a-542g, inclusive, shall be construed to require the insurer or health care center to provide coverage for routine patient care costs that are eligible for reimbursement by an entity other than the insurer, including the entity sponsoring the cancer clinical trial.
44	Sec. 38a-542d. Out of Network (OON) Facility during treatment in a clinical trial. Cancer clinical trials: Routine patient care costs. See Sec. 38a-504d for similar provisions re individual policies	(a) For purposes of sections 38a-542a to 38a-542g, inclusive, "routine patient care costs" means: (1) Coverage for med necessary health care services that are incurred as a result of the treatment being provided to the insured person for purposes of the cancer clinical trial that would otherwise be covered if such services were not rendered pursuant to a cancer clinical trial. Such services shall include those rendered by a physician, diagnostic or laboratory tests, hospitalization or other services provided to the patient during the course of treatment in the cancer clinical trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the insured person were not enrolled in a cancer clinical trial. Such hospitalization shall include treatment at an OON facility if such treatment is not available in-network and not eligible for reimbursement by the sponsors of such clinical trial; and (2) coverage for routine patient care costs incurred for drugs provided to the insured person, in accordance with section 38a-518b, provided such drugs have been approved for sale by the federal Food and Drug Administration.(b) Routine patient care costs shall be subject to the terms, conditions, restrictions, exclusions and limitations of the contract or certificate of insurance between the subscriber and the insurer or health plan, including limitations on out-of-network care, except that treatment at an out-of-network hospital as provided in subdivision (1) of subsection (a) of this section shall be made available by the out-of-network hospital and the insurer or health care center at no greater cost to the insured person than if such treatment was available in-network. The insurer or health care center may require that any routine tests or services required under the cancer clinical trial protocol be performed by providers or institutions under contract with the insurer or health care center. (c) Notwithstanding the provisions of subsection (a) of this section, routine patient care costs shall not include: (1) The cost of an investigational new drug or device that has not been approved for market for any indication by the federal FDA; (2) the cost of a non-health-care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the cancer clinical trial; (3) facility, ancillary, professional services and drug costs that are paid for by grants or funding for the cancer clinical trial; (4) costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the cancer clinical trial; (5) costs that would not be covered under the insured person's policy for noninvestigational treatments, including, but not limited to, items excluded from coverage under the insured person's contract with the insurer or health plan; and (6) transportation, lodging, food or any other expenses associated with travel to or from a facility providing the cancer clinical trial, for the insured person or any family member or companion. **ADMINISTRATIVE REQUIREMENTS IMPACTING CANCER CLINICAL TRIALS NOT EHB** Sec. 38a-542e. Cancer clinical trials: Billing. Payments. Appeals. Sec. 38a-542f. Cancer clinical trials: Standardized forms. Time frames for coverage determinations. Appeals. Regulations. Sec. 38a-542g. Cancer clinical trials: Submission and certification of policy forms.
45	Sec. 38a-543. (Formerly Sec. 38-262j). Age discrimination in	No individual, partnership, corporation or unincorporated association which employs less than twenty employees and provides group hospital, surgical or medical insurance coverage for its employees may reduce the coverage provided to any employee or any employee's spouse solely because he has reached the age of 65 and is eligible for Medicare benefits except to the extent such coverage is provided by Medicare. The terms of

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	group insurance coverage prohibited	any such plan provided by any such employer which employs 20 or more employees shall entitle any employee who has attained the age of 65 and any employee's spouse who has attained the age of 65 to group hospital, surgical or medical insurance coverage under the same conditions as any covered employee or spouse who is under the age of 65.
46	Sec. 38a-546. (Formerly Sec. 38-379). Continuation of benefits under group health policies.	a) In order to assure reasonable continuation of coverage and extension of benefits to the citizens of this state, each group health insurance policy, regardless of the number of insureds, providing coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall, subject to the provisions of subsection (d), contain those provisions described in subsections (b) and (d) of section 38a-554. (b) In any case of the discontinuance of a group health insurance policy and the subsequent replacement of such coverage with another such policy, the succeeding carrier, in applying any deductible, coinsurance or waiting period provisions in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible or coinsurance provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior carrier's plan during the 90 days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible or coinsurance provision. (c) The commissioner shall adopt regulations in accordance with the provisions of chapter 54, covering group coverage discontinuance and replacement. (d) Nothing in this section shall alter or impair existing group policies which have been established pursuant to an agreement which resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement.
47	Sec. 38a-549. Coverage for adopted children. See Sec. 38a-508 for similar provisions re individual policies.	(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) & (12) of section 38a-469 delivered, issued for delivery, amended, renewed or continued in this state shall provide coverage for a child legally placed for adoption with an employee or other member of the covered group who is an adoptive parent or a prospective adoptive parent, even though the adoption has not been finalized, provided the child lives in the household of such employee or member and the child is dependent upon such employee or member for support and maintenance. (b) Coverage for such child legally placed for adoption shall consist of coverage for injury and sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities within the limits of the policy. (c) If payment of a specific premium or subscription fee is required to provide coverage for a child legally placed for adoption with the insured or subscriber who is an adoptive parent or a prospective adoptive parent, the policy may require that notification of acceptance of such child and payment of the required premium or fees be furnished to the insurer, hospital or medical service corporation or health care center within 31 days after the acceptance of such child in order to continue coverage beyond such thirty-one-day period, provided failure to furnish such notice or pay such premium or fees shall not prejudice any claim originating within such 31-day period. (d) Such policy (1) shall cover such child legally placed for adoption on the same basis as other dependents, and (2) may not contain any provision concerning preexisting conditions, insurability, eligibility or health underwriting approval for a child legally placed for adoption, except that an insurer, hospital or medical service corporation or health care center may require health underwriting for a child legally placed for adoption if a required premium or subscription fee and completed application materials are not provided to the insurer, hospital or medical service corporation or health care center before the expiration of the thirty-one-day period following the date the child was legally placed for adoption.
48	Sec. 38a-544. Prescription drug coverage. Mail order pharmacies. See Sec. 38a-510	(a) No medical benefits contract on a group basis, whether issued by an insurance company, a hospital service corporation, a medical service corporation or a health care center, which provides coverage for prescription drugs may require any person covered under such contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs. (b) The provisions of this section shall apply to any such medical benefits contract delivered, issued for delivery or renewed in this state on or after 7/1/1989

#	GROUP and INDIVIDUAL SECTION & TITLE	GROUP STATUTE LANGUAGE
	for similar provisions re individual policies.	
49	Sec. 38a-550. Copayments re in-network imaging services. See Sec. 38a-511 for similar provisions re individual policies.	(a) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a group health insurance policy or contract for magnetic resonance imaging (MRI) or computed axial tomography may (1) require total copayments in excess of $375 for all such in-network imaging services combined annually, or (2) require a copayment in excess of $75 for each in-network MRI or computed axial tomography, provided the physician ordering the radiological services and the physician rendering such services are not the same person or are not participating in the same group practice. (b) No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a group health insurance policy or contract for positron emission tomography may (1) require total copayments in excess of $400 for all such in-network imaging services combined annually, or (2) require a copayment in excess of $100 for each in-network positron emission tomography, provided the physician ordering the radiological service and the physician rendering such service are not the same person or are not participating in the same group practice. (c) The provisions of subsections (a) & (b) of this section shall not apply to a high deductible health plan as that term is used in subsection (f) of section 38a-520.
50	Sec. 38a-546. (Formerly Sec. 38-379). Continuation of benefits under group health policies.	a) In order to assure reasonable continuation of coverage and extension of benefits to the citizens of this state, each group health insurance policy, regardless of the number of insureds, providing coverage of the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of section 38a-469, delivered, issued for delivery, renewed, amended or continued in this state shall, subject to the provisions of subsection (d), contain those provisions described in subsections (b) and (d) of section 38a-554. (b) In any case of the discontinuance of a group health insurance policy and the subsequent replacement of such coverage with another such policy, the succeeding carrier, in applying any deductible, coinsurance or waiting period provisions in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible or coinsurance provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior carrier's plan during the ninety days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible or coinsurance provision. (c) The commissioner shall adopt regulations in accordance with the provisions of chapter 54, covering group coverage discontinuance and replacement. (d) Nothing in this section shall alter or impair existing group policies which have been established pursuant to an agreement which resulted from collective bargaining, and the provisions required by this section shall become effective upon the next regular renewal and completion of such collective bargaining agreement.